RHODE ISLAND CHRONIC CARE SUSTAINABILITY INITIATIVE AGREEMENT

This Rhode Island Chronic Care Sustainability Initiative Agreement (the "Agreement") is entered into this _____ day of _____ 2012, by and between XXXX Company on behalf of itself and the other entities that are United's Affiliates, (hereinafter "Plan"), and _____ (the "Provider").

W I T N E S S E T H:

WHEREAS, the Plan and the Practice desire to enter into an agreement for the funding toward the Rhode Island Chronic Care Sustainability Initiative ("CSI-RI") on the terms and conditions set forth herein; and

WHEREAS, the Practice shall be a group of primary care providers (practitioners) or a solo practitioner in the Plan's network pursuant to a Medical Group Participation Agreement with Plan (hereinafter "Group Agreement") and

WHEREAS, CSI, a Multi-Payer Demonstration of the Patient-Centered Medical Home ("PCMH"), a model of primary care that will improve the care of chronic disease and lead to better overall health outcomes for Rhode Islanders.

NOW, THEREFORE, in consideration of the mutual covenants, promises and undertakings hereinafter set forth and for other good and sufficient consideration, the receipt of which is hereby acknowledged, the parties hereto agree as follows:

I. PRACTICE SITE PARTICIPATION

A. The Practice Site participating under this Agreement and its Providers as of the date of this contract includes:

[Insert Expansion Practice Site Name]

Provider Names	Practitioner Type (physician or physician extenders)	NPI number

B. The other practices and their respective practitioners participating in CSI-RI and covered under terms identical to or substantially similar to this Agreement (each group will execute its own separate contract) and who will be measured collectively with Practice, and will collectively be defined as "CSI Practices" include:

CSI Pilot Sites

Coastal Medical
41 Sanderson Road
Smithfield, RI 02917

Family Health & Sports Medicine
725 Reservoir Avenue
Cranston, RI 02910

Hillside Avenue Family and Community Medicine

727 East Avenue
Pawtucket, RI 02860

Thundermist Health Center
450 Clinton Street
Woonsocket, RI 02895

University Medicine Foundation
285 Governor Street, Suites 200 and 300
Providence, RI 02906

CSI Expansion sites

Coastal Medical, Inc – Wakefield
70 Kenyon Ave, Suite 215
Wakefield, RI 02879

Dr. Kristine Cunniff, MD
350 Kingstown Road
Narragansett, RI 02882

Dr. Stuart Demirs
4099 Old Post Road
Charlestown, RI

The Independent Practices of Kostrzewa,
Gonzalez, Maguire, and Degood
Narragansett Medical Building
360 Kingstown Rd, Suite 200
Narragansett, RI 02882

Memorial Hospital Family Care Center
111 Brewster Street
Pawtucket, RI 02860

South County Hospital Family Medicine
100 Kenyon Ave
Wakefield, RI 02879

South County Internal Medicine
481 Kingstown Road
Wakefield, RI 02879-3626

Thundermist Health Center – Wakefield
1 River Street
Wakefield, RI 02879

C. The Plan reserves the right to limit PMPM payments as described in Section II Compensation herein to the number of physicians and physician extenders ("Practitioners") listed in Section I.A. In the event that the Practice employs a new practitioner at the practice site, the new Practitioner shall be included in PMPM calculations if he or she is replacing one of the Practitioners identified in Section I.A. If the new Practitioner is being added to the practice site and is not replacing an existing Practitioner, the new Practitioner shall be included in PMPM calculations. However, if the Practice patient attribution increases

more than 25% from its original attribution as described in Section II B as a result of the practice site adding a Practitioner that is not replacing an existing Practitioner, then the additional PMPM payment will be paid at the discretion of the Plan. Notwithstanding above, the parties agree that any physician Practitioner added to a practice site must first be added to the underlying Group Agreement between the parties. Practices serving NHP members will have their PMPM calculations based upon member assigned to said practice.

D. Should the Practitioners identified in this Section I. A change, the Practice will notify CSI and the Plan with the practitioner name, NPI number (if applicable), and the effective date of the change.

II. COMPENSATION

A. The Practice shall be paid the following per member per month payments ("PMPM") provided that all of the conditions of this Agreement are met including Section III: Other Performance Requirements, and achieving "Targets" as defined in section, II.F.:

1. Contract Year: Start-up Year (insert dates): Practice will be paid $4.50 PMPM for each Eligible Subscriber.
2. Contract Year: Transition Year (insert dates): Practice will be paid $5.50 PMPM for each Eligible Subscriber.
3. Contract Year: Performance Year I (insert dates): Practice's Compensation will be paid at a scaled rate based upon performance:
    a. The Practice will be paid $5.00 PMPM for each Eligible Subscriber if no Target or only one Target is met; or
    b. The Practice will be paid $5.50 PMPM for each Eligible Subscriber if two of three targets are met (Target #1, Target #2 or Target #3); or
    c. The Practice will be paid $6.00 PMPM for each Eligible Subscriber if all three Targets are met.
4. Contract Year: Performance Year II (insert dates): Practice's Compensation will be paid at a scaled rate based upon performance:
    a. The Practice will be paid $5.00 PMPM for each Eligible Subscriber if no Target or only one Target is met; or
    b. The Practice will be paid $5.50 PMPM for each Eligible Subscriber if two of three targets are met (Target #1, Target #2 or Target #3); or
    c. The Practice will be paid $6.00 PMPM for each Eligible Subscriber if all three Targets are met.
5. Contract Year e: (insert dates): There is an option to renew the contract for a one year period upon mutual agreement of both parties.
6. If a practice or group of practices choose(s) to contract with another practice or outside entity to provide NCM services (per section IIE below), their PMPM payment will be reduced by $1.50, and said $1.50 payment will be paid to the practice or entity providing the NCM services.

Comment [MM1]: With the potential for future expansion sites on the horizon, creating a developmental contract allows practices to come in at the appropriate level. Creating these contract years will also help to align all current and future practices on the same contract cycle. See section "III, B" or Contract Year grid for breakdown of "Start-up, Transition, Performance Year I and II"

Comment [MM2]: Generic language was produced to reflect the model currently in use in South County, without referencing South County Hospital specifically.

B. Payments made per member per month ("PMPM") will be made for Eligible Subscribers subject to the following definitions and requirements.

1. *Eligible Subscribers means Commercial Subscribers, RItecare Subscribers, and Medicare Subscribers who receive coverage on a fully-insured basis or self-insured basis and who are entitled to receive Covered Health Services as described in their respective Subscriber Agreements pursuant to the benefit* programs underwritten or marketed by the Plan; Eligible RIteCare Subscriber payments will only be made for those products with two hundred (200) or more Eligible Subscribers.

Comment [B3]: This will need to be adjusted based on the particular products offered by the Plan

2. Only Eligible Subscribers that either through self-selection or, in the absence of self-selection, through assignation to a Practitioner through an attribution methodology to a physician or Practitioner listed in

Section I.A., shall qualify as counting for purposes of the PMPM payments hereunder. Practices serving NHP members will have their PMPM calculations based upon member assigned to said practice.

3. The CSI attribution methodology for Plan's Eligible Subscribers will be defined as:

   a. Eligible Subscribers with the most recent PCP Visit rendered by the Practitioner/Provider. "PCP Visit" is defined as an evaluation & management ("E/M") visit rendered by a Primary Care Physician as credentialed by the Plan with a specialty in Internal Medicine or Family Practice (or any midlevel practitioners employed by the practice providing primary care services). E/M visits are defined as CPT® codes 99201-99215 and 99381-99397. NCM codes could also be included once such codes are approved by Medicare. The Plan will calculate the number of Eligible Subscribers each quarter based on twenty-seven (27) months of claims data. Eligible Subscribers must be active Plan Subscriber as of the date indicated below in the payment schedule table (see Section IV d.2 for reporting requirements regarding Eligible Subscribers).

Comment [MM4]: With Nurse Care Manager Codes potentially being approved by Medicare, there is option for the use of these codes for attribution purposes.

A PCP is defined as a primary care physician as credentialed by the Plan with a specialty in Internal Medicine or Family Practice (or any midlevel practitioners employed by the Internal Medicine or Family Practice providing primary care services).

CSI Management will track quarterly attribution by the Practice and by the Plan with a report submitted to the Executive Committee.

C. PMPM payments for Eligible Subscribers (as defined in Sections A –B above) shall be made to Practice prospectively on a quarterly basis and no later than the third week of the first month of each quarter. The schedule of payments follows:

PMPM Payment Schedule

	Contract Quarter:	Paid Claims Ending:	Active with Plan
1	October 1 – December 31, 2012	August 31, 2012	October 1, 2012
2	January 1 – March, 31 2013	November 30, 2012	January 1, 2013
3	April 1 – June, 30 2013	February 28, 2013	April 1, 2012
4	July 1 – September, 30 2013	May 31, 2013	July 1, 2013
5	October 1 – December 31, 2013	August 31, 2013	October 1, 2013
6	January 1 – March 31, 2014	November 30, 2013	January 1, 2014
7	April 1 – June 30, 2014	February 28, 2014	April 1, 2014
8	July 1 – September 30, 2014	November 30, 2013	July 1, 2014

Comment [K5]: Will need to be updated

PMPM Payment Due Dates

Comment [K6]: 1.Will need to be updated with final dates

Contract Period		PMPM Payment Due Date
October 1 – December 31, 2012	Quarter 1	October 21, 2012
January 1 – March, 31 2013	Quarter 2	January 20, 2013
April 1 – June, 30 2013	Quarter 3	April 21, 2013
July 1 – September, 30 2013	Quarter 4	July 21, 2013
October 1 – December 31, 2013	Quarter 5	October 20, 2013

January 1 – March 31, 2014	Quarter 6	January19, 2014
April 1 – June 30, 2014	Quarter 7	April 20, 2014
July 1 – September 30, 2014	Quarter 8	July 20, 2014

D. PMPM payments are subject to Practice adherence to NCQA PCMH Standards and the terms of this Agreement, and shall be paid in accordance with Section III herein.

E. Nurse Care Managers ("NCM"). NCMs will be hired by the Practice to support the implementation and maintenance of the Patient Centered Medical Home ("PCMH") elements including but not limited to the coordination of care. Compensation for the NCM is included in the PMPM payments outlined in Section II.A. It is the expectation that the Practice will have a dedicated NCM retained to support the type of functions listed in Attachment A. If at any time the Practice reasonably expects to be without a NCM for a period of 30 days or more, the Practice will notify the CSI-RI Steering Committee and the Plan. If more than 30 days passes and the Practice has not been able to replace the NCM, the parties will attempt to reach a mutually agreeable alternative arrangement to replace the services provided by the NCM. However, if a mutually agreeable alternative is not agreed upon, the Plan will have the unilateral right to reduce the PMPM by an amount of no more than $1.50 or terminate this Agreement with the Practice.

Deleted: 9

F. "Target" refers to the three (3) measures outlined in Section II.F.1. – F.3 below; specifics related to the definitions of the metrics and how performance will be measured are outlined in this Agreement. Target #1 and #2 will be measured based on the Practice's sole performance; Target #3 1a) Inpatient admission and 1b) ED visits will be measured based on the aggregate performance of CSI Practice sites as described under Section I A. and B. of this Agreement. (See Section VI a. for procedures to be used in case of disputes in the calculation of Target results). Practices will agree to un-blinded, public reporting of approved performance metrics on the PCMHRI website, amongst the CSI community.

Comment [MM7]: For the sake of best practice sharing an open CSI community, unblended data results will be required. No CSI practice has had an objection to their data being public amongst the CSI-Beacon Community.

1. **Target # 1: Process Improvement (Practice Metric): Practice will demonstrate to the Plan's satisfaction successful implementation and maintenance of the following Process Improvement metrics:**

a. After Hours: The Practice will submit to CSI-RI Management the After Hours Protocol and Plan for Monitoring Performance. The protocol for the Practice will include, the strategy for accessing weekends, holidays & extended hours of care location, hour of operations and protocols outlining how for Practice's Eligible Subscribers can access care from these sites as an alternative to emergency room care. CSI-RI Management will submit to the CSI-RI Executive Committee for review and approval. The approved After Hours Program must be in operation no later than (insert date 6 months after start of contract = March 31, 2013).

Comment [MM8]: Incentive Structure has been turned around to lead with process improvement measures. With so much emphasis being placed on Utilization in the last contract, practices' performance incentives were dependent on Utilization to avoid penalty. In this new version of the common contract, targets are equally incentivized.

b. Hospital – Outpatient transition best practices: compliant with the Quality Partners of Rhode Island, "HOSPITAL & COMMUNITY PHYSICIAN BEST PRACTICES" (see Attachment D).

c. Compacts with high volume specialists: Practice will establish compacts consistent with Attachment E.: "Colorado Primary Care - Specialty Care Compact" and "American College of Physicians Council of Subspecialty Societies (CSS) Patient-Centered Medical Home (PCMH) Workgroup" such that one (1) compact is established and approved by the Plan by (insert date = 3 months after Dec 31, 2012). Two (2) additional compacts are established by the Practice and approved by the Plan by (insert 6 months after = March 31, 2013) and a total of no less than four (4) compacts with four (4) different specialties shall be established by (insert date 9 months after = June 30, 2013) and maintained for the term of this Agreement. One of the compacts must be with a hospitalist unless Practice provides inpatient care for all of Practices Eligible Subscribers at the Practice's primary hospital. Eligible Subscribers receive inpatient services.

d. Practice must also meet the NCM quarterly reporting requirements to CSI Management.

2. **Target # 2: Quality and Patient Experience (Provider Metrics):** Reporting and Measurement for Target # 2 will be reviewed annually by the CSI-RI Data and Evaluation Committee with recommendations to the CSI-RI Executive Committee to modify the specific benchmarks.

Comment [MM9]: Pilot site contracts contain measures and benchmarks that are already outdated. This language provides room for adjustment of both Quality reporting and patient experience measures.

3. Quality: Practice will achieve the CSI clinical quality measures as defined in Attachment B: Reporting and Measurement for Target #2. If the benchmark is not achieved, the target will also be considered as met if the Practice achieves half the distance between the baseline rate and the target, as long as half the distance equals at least a 2.5 % point improvement. The quality measures are based on industry- standards metrics. See Attachment B: Reporting and Measurement for Target #2.
4.

5. Patient Experience: Practice will allow the conduct of the CAHPS-PCMH survey and present findings to the RI CSI Executive Committee by the end of the transition year, along with a plan for the incorporation of these findings into their practice redesign. See Attachment B: Reporting and Measurement for Target #2.

Comment [MM10]: This language assures that practices will not be responsible for the cost of administering the CAHPS-PCMH survey

6. **Target #3: Utilization Metric (CSI Provider Metric):**

a. CSI Practices will achieve a five percent (5%) relative reduction in hospital admissions per thousand as compared to similar, non –PCMH providers during the same measurement period. "Non-PCMH practices" will be defined by the Data and Evaluation Committee and approved agreed to Executive Committee and voting members of the by the CSI-RI Steering Committee.

   For example, if the comparison non- PCMH practices have decreased their rate of hospitalization from 50 hospital admission / 1000 to 49 hospital admissions / 1000 (2% reduction) , CSI Practices will achieve a rate deduction of 7 % to meet target: i.e. 75 hospital admissions / 1000 to (75– [75 X .07]) = 69.75 hospital admissions / 1000).

b. CSI Practices will achieve ten percent (7.5%) relative reduction in ED visits per thousand as compared to similar, non –PCMH practices during the same measurement period.

   For example, if the comparison non- PCMH practices decreased their rate of ED visits from 300 ED visits / 1000 to 270 ED visits / 1000 (10 % reduction), CSI Practice will achieve a reduction of 20% to meet target: 250 visits / 1000 to (250 – [250 X .20] = 200 ER visits /1000).

7. Target #3 will also be considered met if either 3.a. or 3.b. measure exceeds target by one point or more and 75% or more of the other target is achieved.

8. Target #3 is an annual measure and will be based on comparison utilization activity for the (insert date of calendar year which ends 3 months before the start of the transition year) "Base Year" as compared to the (insert date of calendar which ends 3 months before start of performance year I) "Performance Year". The performance results shall be created and reported as follows:

a. Plan shall provide to the data aggregator and evaluation vendor identified by CSI Project Management sufficient claims detail by product to support the reporting for the Inpatient and ER metrics as identified in Target #3. As of 2/28/12 the data aggregator is the Rhode Island Quality Institute and evaluator is RTI. The specific data requirements are defined by the Reporting and Data Committee and approved by the CSI-RI Steering Committee on (04/13/12).
b. Plan shall provide the claims data ninety (90) days after the end of "Base Year" (insert date).
c. CSI Project Management designated vendor will aggregate and report the results within thirty (30) days of receipt of all of the Plans' data.

d. Plan will then make the necessary retro-active payment adjustment (if any) and pay the revised PMPM consistent with the earned amount for Targets #1 -3 with Contract Quarter 6 payment.

G. If at any time during this Agreement a Practice does not meet the minimum requirements as outlined by this Agreement, the Plan has the right to adjust the funding accordingly and /or terminate the funding associated with the Practice's participation in the program. Partial payments will not be made for partial achievement unless otherwise defined in this Agreement.

H. If this Agreement is terminated for cause or as the result of a dispute or grievance in accordance with Section VI herein, PMPM compensation payments will be paid until the date of termination. If the Plan has made or makes any prospective payments beyond the termination date, such payments shall be returned to the Plan within thirty days of termination.

III. OTHER PERFORMANCE REQUIREMENTS

A. The Practice shall refer/coordinate Eligible Subscribers' care to providers contracted with the Plan at all times except when it is medically necessary to use a non-participating Plan provider (cases requiring emergency level of care), unless the Eligible Subscriber has elected to use the non-participating provider and assumes all or some of the costs of the service. In all cases, the Practice should provide necessary clinical information to coordinate the care of Eligible Subscribers, whether or not Plan or the Eligible Subscriber is responsible for some or all of the cost of care. Contracted providers include physicians and hospitals as well as ancillary providers; such as, clinical and pathology laboratories, durable medical equipment and behavioral health providers.

B. The Practice must meet the following performance requirements:

Comment [MM11]: Contract years are broken down to represent different levels of practice transformation. Once again, this allows us to add practices to CSI that are currently performing at different levels.

Start-up Year
The Practice must meet the following structural elements in order to receive compensation as outlined in Section II – Compensation.

A. Element #1: Electronic Medical Record
The Practice must have an electronic medical record in place meeting meaningful use standards.

B. Element #2: Nurse Care Managers (NCMs) Hired and Trained
The Practice must have hired and trained Nurse Care Managers per the Nurse Care Manager Role and Responsibilities outlined in Attachment A.

C. Element #3: NCQA Patient-Centered Medical Home Recognition
The Practice shall demonstrate substantial efforts to achieve and maintain Level 1 recognition as defined by the NCQA – Patient-Centered Medical Home version Standards ("NCQA-PCMH standards"), by the end of the Start-Up Year in order to receive the compensation as outlined in Section II - Compensation. If level 1 recognition is not achieved the practice will work with CSI Project Management to make a plan for resubmission in (6) six months. If after the second submission, the practice fails to achieve level 1 recognition, continued participation in the CSI Project shall be reviewed and determined by voting members of the CSI-RI Steering Committee. Upon completion of the evaluation, the Provider shall disclose to CSI Management all content and scoring related to the evaluation.

Transition Year
NCQA Patient-Centered Medical Home Recognition
The Practice shall demonstrate substantial efforts to achieve and maintain Level 2 recognition as defined by the NCQA – Patient-Centered Medical Home version Standards ("NCQA-PCMH standards"), by the end of the Transition Year in order to receive the compensation as outlined in Section II - Compensation. If level 2

recognition is not achieved the practice will work with CSI Project Management to make a plan for resubmission in (6) six months. If after the second submission, the practice fails to achieve level 2 recognition, continued participation in the CSI Project shall be reviewed and determined by voting members of the CSI-RI Steering Committee. Upon completion of the evaluation, the Provider shall disclose to CSI Management all content and scoring related to the evaluation.

Performance Year I
NCQA Patient-Centered Medical Home Recognition
The Practice shall document a plan to achieve Level 3 recognition as defined by the NCQA – Patient-Centered Medical Home version Standards ("NCQA-PCMH standards"), by the end of Performance Year I in order to receive the compensation as outlined in Section II – Compensation.

Performance Year II
NCQA Patient-Centered Medical Home Recognition
The Practice shall demonstrate substantial efforts to achieve and maintain Level 3 recognition as defined by the NCQA – Patient-Centered Medical Home version Standards ("NCQA-PCMH 2011 standards"), by the end of Performance Year II in order to receive the compensation as outlined in Section II - Compensation. If level 3 recognition is not achieved the practice will work with CSI Project Management to make a plan for resubmission in 6 six months. If after the second submission, the practice fails to achieve level 3 recognition, continued participation in the CSI Project shall be reviewed and determined by voting members of the CSI-RI Steering Committee. Upon completion of the evaluation, the Provider shall disclose to CSI Management all content and scoring related to the evaluation. For plans who are re-submitting for their level 3 recognition, if level 3 recognition is not achieved the practice will work with CSI Project Management to make a plan for resubmission in 6 six months. This will result in a reduction in the PMPM until level 3 recognition is regained. If after the second submission, the practice fails to regain level 3 recognition, continued participation in the CSI Project shall be reviewed and determined by voting members of the CSI-RI Steering Committee. Upon completion of the evaluation, the Provider shall disclose to CSI Management all content and scoring related to the evaluation.

IV. TRAINING AND REPORTING

A. The Practice shall participate in training as established by a training and support entity selected by the voting members of the CSI-RI Steering Committee. If at any time Practice fails to meet the training requirements, PMPM payments as defined in Section II Compensation herein shall be eliminated until such time as training requirements are completed. Completion status will be determined by the voting members of the CSI-RI Steering Committee.

B. The Practice shall endeavor to engage its patients in the CSI-RI program. Patient Engagement is defined as communication from the Practice to an Eligible Subscriber about the PCMH initiative and the additional services that are made available. Patient Engagement shall be documented in the Subscriber's medical record.

C. The Practice and, at the Plan's discretion, the Plan will participate in evaluations of CSI-RI conducted by a reviewer mutually agreed upon by the parties hereto and the CSI-RI Steering Committee, and provide data or other information requested as part of the evaluation. The Plan agrees to comply with reasonable requests.

D. The Plan agrees to provide to the Practice and to CSI Management, the following reports (except as noted) related to the Plan's Eligible Subscriber population:
    1. Hospital Emergency Department (ED) visits / 1000 - Quarterly
    2. Percentage of Eligible Subscribers with greater than two (2) ED visits within ninety (90) days - Quarterly
    3. Hospital admissions / 1000 – Quarterly

4. Subscriber Panels – Quarterly (practice only)
5. Subscriber Inpatient and ED Utilization – Weekly (practice only)
6. Attribution List - Quarterly
7. Quarterly high dollar imaging activity / number of tests ordered by category (additional fields may be added at the Plan's discretion that represent the Provider's performance against national benchmarks)
8. Other reports as agreed to by the Plan

E. The Practice agrees to provide the following reporting consistent with Attachment C. Quarterly Reporting Due Dates unless specified otherwise in this Agreement:

1. Target #2 Quality and Patient Experience Metrics:
2. Process Measures for the following:
    a. After Hours of Care
    b. Participation in Hospital – PCP Transition best practices
    c. Compacts established with four (4) specialty groups (including one compact with a hospitalist)
    d. Patient Experience Survey
    e. Nurse Care Manager Activities

F. Reporting values will be rounded to the nearest tenth of a digit for measurement purposes related to the Targets.

G. Plan will contribute to the RI "All Payer" data base, if available, and if Plan has sufficient claims detail to calculate the agreed upon CSI utilization metrics outlined in this Agreement. In the absence of the "All Payer" data base, the Plan will submit claims data to the RI Quality Institute's Claims Extract.

H. Plan will report to Practices three (3) additional measures selected through statewide "harmonization" which for purposes of this Agreement shall mean selecting measures that are consistent with the standard measures being used in various statewide initiatives related to primary care. Measures will be determined by mutual agreement between the various plans in PCMH, the Practice and the CSI-RI Steering Committee through the harmonization process. Type of measures to be considered include:

1. Ambulatory Care Sensitive Admissions / 1000
2. Thirty (30) day hospital re-admissions/ 1000
3. Ambulatory Care Sensitive ED visits

V. USE OF DATA

A. Plan shall have the right to publish the clinical outcome data derived from this PCMH program in an aggregate fashion.

B. Should data from this PCMH program indicate a practitioner is operating at a level which would be an imminent threat to patients, this data can be used in individual practitioner termination proceedings and any required regulatory reporting.

VI. TERM AND TERMINATION

This Agreement shall commence on (insert date) and shall continue thereafter until (insert date), unless this Agreement is earlier terminated as set forth in this Section VI.

A. The Practice and the Plan hereto encourage the prompt and equitable settlement of all disputes or grievances arising from or related to this Agreement except for items specified under the section on cause for termination of contract. The parties agree to negotiate their differences directly and in good faith. If resolution is not possible, the issue will be referred to the voting members of the CSI-RI Steering Committee for review and comment. If the dispute or grievance is deemed irreconcilable following review by the CSI-RI Steering Committee, either party hereto may terminate this Agreement by providing the other party with not less than ninety (90) days' prior written notice of termination. Notwithstanding the above, this section is intended to apply only to disputes related to subject matters governed under this Agreement related to the PCMH program. Any other disputes between the parties shall be resolved pursuant to the dispute resolution terms contained in the underlying Group Agreement between the parties.

B. Either party hereto may terminate this Agreement immediately for cause as set forth below:
   1. material breach by the other party of any of the terms or conditions of this Agreement which is not cured within thirty (30) days following receipt by the breaching party of a notice of deficiency specifying the nature of the breach; or
   2. fraud committed by either party upon written notice; or
   3. failure to comply with applicable state and federal rules and regulations upon written notice; or
   4. loss or suspension of licenses/certifications necessary to fulfill this Agreement upon written notice; or
   5. the other party hereto shall commit an act of bankruptcy within the meaning of the federal bankruptcy laws, or bankruptcy, receivership, insolvency, reorganization, liquidation or other similar proceedings

C. Additionally the Plan may terminate this Agreement for cause as set forth below:
   1. if the Practice becomes a non-participating Plan practice at any time during this Agreement; or
   2. if the Practice is expelled or suspended from the Medicare or Medicaid programs.
   3. lack of need of Plan to continue with this Agreement as a result of economic considerations upon no less than ninety days (90) prior written notice.

Notwithstanding the above, the parties agree that, in the event Plan terminates an individual practitioner subject to this Agreement from the underlying Group Agreement with Practice pursuant to Plan's rights there under, this Agreement will remain valid with regard to the remaining practitioners.

D. Any notice of termination hereunder shall set forth the reason(s) for such termination. Upon termination of this Agreement, for whatever reason, the rights and obligations of the parties hereunder shall terminate. Termination of this Agreement shall not release Practice or each physician from providing services in accordance with the terms of such individual's Participating Agreement or Provider's Participating Provider Agreement and such Participating Agreement or Participating Provider Agreement shall remain in full force and effect until terminated in accordance with its terms.

VII. MISCELLANEOUS

A. The Practice hereby expressly acknowledges such Practice understands that this Agreement constitutes a contract between the Practice and the Plan and that the Plan is an independent corporation operating under a license from [Health Plan]. The Practice further acknowledges and agrees that it has not entered into this agreement based upon representations by any person or entity other than Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the Practice for any of the obligations of Plan to the Practice created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of this Agreement and all other rights available by law.

B. The Practice shall comply with all rules, regulations, policies and amendments thereto which are communicated to the Practice.

C. In support of this Patient-Centered Medical Home Initiative, should the RI CSI Executive Committee vote for specific activities, such voting will override these contractual terms, so long as they are not disputed by the Plan.

D. All notices, authorizations or other communications required to be given pursuant to the terms and provisions of this Agreement shall be in writing and personally delivered or sent by overnight delivery, or by certified mail, return receipt requested, and shall be deemed to be duly delivered upon receipt at the following address:

If to xxx: [Health Plan]
_____
Attn: Network Management

If to the Provider: _____insert_____
_____
_____
_____

E. This Agreement constitutes the entire agreement of the parties relative to CSI-RI. The parties agree that the terms and conditions set forth in the underlying participating provider Group Agreement remain enforceable and take precedence over the terms of this Agreement with regard to the subject matter thereof and shall govern in the event of a direct conflict. This Agreement shall be construed under and governed by the laws of the State of Rhode Island. The invalidity or unenforceability of any provision hereof shall in no way affect the validity and enforceability of any other provisions. The waiver by either party of a breach or violation of any provision hereof shall not operate or be construed as a waiver of any other breach or violation hereof. Neither this Agreement nor any interest herein shall be assigned by the Practice without the express prior written consent of Plan, which consent may be withheld in the sole and absolute discretion of Plan.

F. The parties hereto are independent entities and neither of them nor any of their respective employees shall be construed to be the agent, employer or representative of the other, nor shall either party have any expressed or implied right or authority to assume or create any obligation on behalf of or in the name of the other party. Neither party shall be liable to the other for any act or omission of the other party hereto.

IN WITNESS WHEREOF, the parties have executed this Agreement in duplicate originals on the day and year set forth below.

[Provider]	Plan
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
Title:_____	Title: _____